



**Women's Health Grant Program**  
Breast & Cervical Health  
*"Keeping Delta Women Strong"*

TOLL FREE: 1-800-478-3321  
Fax: 907-543-6689  
Care Manager: Jackie 543-6296



**About Our Program**

Dear Valued Client,

The Women's Health Program understands how difficult it can be to remember breast and cervical screenings on a yearly basis. We know how confusing and scary the whole process can be. And we also know how expensive it can be to get to an appointment.

The Women's Health Program provides:

- Notification when screenings are due.
- Education about various processes, procedures, and the value of timely screening.
- Travel to the nearest health facility, if eligible.
- And support groups (for information call 543-4087 and ask for Bunny)

If you are between the ages 18 and 64 you may be eligible. To help us determine your eligibility, please answer the questions found on the backside of this paper and return to:

- Mail: Women's Health Grant Program, P.O. Box 287, Bethel, AK 99559
- Fax: 907-543-6689
- In person: Drop it off at the YKDR Hospital, in the Community Relations Dept. or simply give it to your health aide.

Please submit your enrollment form so that we receive it at least 3-4 days before your appointment.

For questions, call the toll free number or our care manager at the numbers listed on the top of the page.

Thank you for completing the enrollment form. By doing so you are helping secure our services for all who need them.

"Take care of your loved ones by taking care of yourself."

Thank you!



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**Annual Enrollment Form**

**!!Must be between the ages of 18 and 64!!**

1. Today's Date: \_\_/\_\_/\_\_

2. Client Information: (Please Print)

a. Name: \_\_\_\_\_

b. Date of Birth \_\_/\_\_/\_\_

c. Where do you live?: \_\_\_\_\_

d. What is your race? (Please check ALL that apply)

Alaskan Native or American Indian

Asian

African American

Native Hawaiian/Other Pacific Islander

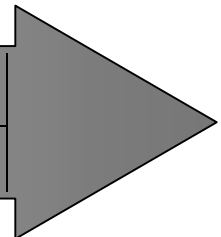
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Unknown

3. Household Information: Please circle your household size (including yourself) and maximum monthly income (including dividends, child support and public assistance).

**Household**

Size	1	2	3	4	5	6	7	8	9
Monthly Income	\$2,552 or less	\$3,438 or less	\$4,323 or less	\$5,208 or less	\$6,094 or less	\$6,979 or less	\$7,865 or less	\$8,750 or less	\$9,635 or less



4. Do you have any of the following?

Medicare

Medicaid

Private Insurance \_\_\_\_\_

None of the Above

5. Do you have a Women's Health Appointment? (Check only one box)

Yes, my appointment date is: \_\_/\_\_/\_\_ time: \_\_:\_\_ am pm

No, I will call registration at 543-6442 to schedule an appointment

No, please contact me for help scheduling an appointment. My phone: \_\_\_\_\_

6. Do you have a family history of Breast Cancer?

No  Yes, \_\_\_\_\_(who?)

7. Would you like help paying for travel?  No  Yes

**By taking part in this program, I give permission to any and all of my doctors, clinics and/or hospitals to provide all information concerning my Pap smear, breast exams and mammograms, and any related diagnosis or treatments to the YKHC Women's Health Program. All information shared with the BCCP Program will remain confidential. This means that the information will be available only to me (the patient) and to the employees of the BCCP Program. This information will be used only for the purposes of the program and any reports will not identify me by name. I understand that my participation is voluntary and that I may drop out of the Program and withdraw my consent to release information at any time.**

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_